Commonwealth of Kentucky

Commission on Services and Support for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (HB 843 Commission)

Commission Retreats: 9/13/06 and 12/13/06: Responding to Citizens Experiencing Behavioral Health Crises

Consultant Summary Report

December 2006

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Kentucky HB 843 Commission
Crisis Response System Consultation

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Introduction

During the legislative session of 2000, the Commonwealth of Kentucky enacted House Bill 843, establishing a commission to address the need for a comprehensive state plan to serve Kentuckians who suffer from mental illness, substance abuse disorders, or both. The Commission has been working since that time to address its mandate and improve mental health, chemical dependency and co-occurring disorder services across the state.

As part of this process, in 2006 the National Association of State Mental Health Program Directors provided a technical assistance grant to the Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) to address the needs of citizens experiencing behavioral health crises who were frequent users of hospital emergency rooms across the state. David Wertheimer, Principal Consultant with Kelly Point Partners of Seattle, Washington, was engaged to facilitate two retreats of the HB 843 Commission to address this specific issue. This report documents the process and recommendations that emerged from this process.

Background Context

Over the past several years, the Commonwealth of Kentucky has lost over 300 private sector inpatient psychiatric beds. At the same time, budgetary constraints have been placed upon state hospital facilities, severely limiting access to inpatient care for people with mental illnesses. These changes have created a significant dilemma for citizens who are experiencing a mental health crisis and who are homeless, unemployed and/or uninsured. These individuals are often brought to hospital emergency rooms, where they cannot legally be turned away. Many of these hospitals are small and/or in rural areas and do not maintain either licensed psychiatric beds or separate psychiatric emergency rooms; these facilities are ill equipped to handle this influx of psychiatric patients.

In July 0f 2003 the Kentucky Education and Research Foundation conducted a survey of hospital emergency room personnel to better understand the scope of this problem. Of those responding, 96% reported having difficulty obtaining timely mental health services for their emergency room patients. Barriers to obtaining these services include:

- Delays in response time or availability of mental health professionals for consultation
- Availability of space at behavioral healthcare facilities
- Confusion regarding proper transport of patients to another facility
- Lack of acceptance of responsibility for patients due to risk management concerns

NASMHPD Project Overview

The National Association of State Mental Health Program Directors (NASMHPD) made funds available to the Commonwealth for this initiative as part of the *Targeted Technical Assistance* project. NASMHPD directs this project under contract with the Division of

State and Community Systems Development, the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. NASMHPD provided this funding to help address the issues identified above. The goals of the initiative, to be stimulated in part by this initial technical assistance activity, include:

- Improving the overall quality of mental health care
- Providing timely assessment, stabilization, and transport of voluntary mental health consumers into crisis networks, thereby averting costly hospitalization
- Creating collaborative arrangements between hospitals, mental health centers, law enforcement agencies, and emergency medical services to enhance care to voluntary patients experiencing mental health crises
- Conveying evidence-based "best practices" and tools available to assist all parties in appropriately responding to voluntary patients in psychiatric crisis mental health at the local level
- Discussing the most advantageous process for emergency room staff and physicians to stabilize persons in psychiatric crisis, contact appropriate agency for assessments, and arrange transfer of voluntary patients to the proper facilities

The initial technical assistance activities was comprised of three key components.

1. Convening of a one-day retreat of key state-level stakeholders with knowledge and expertise related to local and state hospitals, community mental health centers, law enforcement agencies and emergency medical services to clearly define the issues as defined by different stakeholder groups as well as the gaps and barriers that are preventing a timely resolution of the issues. *(Completed, September 13, 2006)*

2. Development of a template and procedure for local communities to utilize to map effective potential pathways to help for individuals experiencing mental health crises and recommendations from the state level systems to help guide local communities in developing more effective partnerships to promote effective voluntary crisis response services. *(Completed, November 2006)*

3. Convening a follow-up meeting of stakeholders at the State level to review the template, procedures and recommendations for use in local communities and develop strategies for effective implementation of systems change efforts throughout the Commonwealth focused on improving crisis response services for voluntary behavioral health clients. *(Completed, December 13, 2006)*

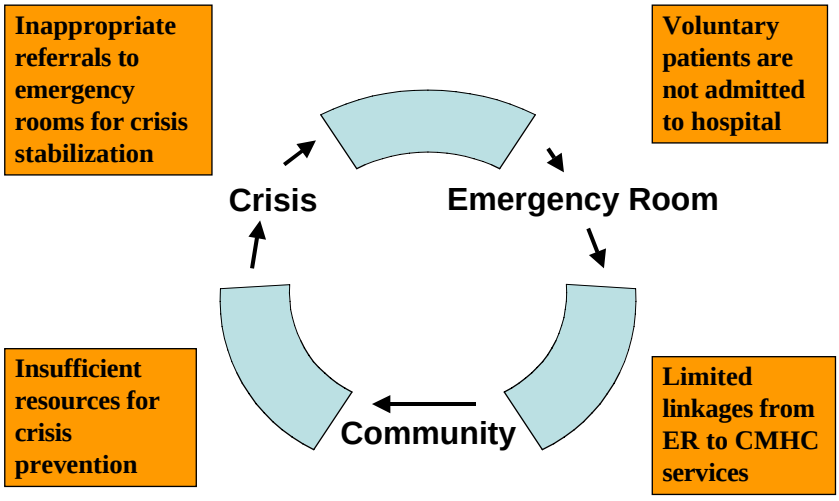
Summary of the Problem/Issue

The core issue addressed during this technical assistance process was the cycling through the emergency service system of individuals in the community experiencing an acute behavioral health crisis. Within this group, particular focus was placed on those individuals who present at hospital emergency rooms in the midst of a crisis who do not

meet the criteria for involuntary detention under the existing criteria of the state's involuntary commitment laws (202A).

The nature of this cycle is illustrated in the following chart, below:

Chart #1:
Behavioral Health Crisis Emergency Services Cycle



September 13 Retreat Work Products

During its first retreat, the HB 843 Commission divided into four groups to discuss specific elements of the problem of individuals cycling from crisis situations in the community into emergency rooms and back to the community. These four groups addressed the following topic areas:

1. **Pathways In:** How individuals in crisis end up at local emergency rooms, and the nature of the activities that occur at the very front end of a crisis situation
2. **Emergency Rooms and Crisis Services:** What happens at the point of contact with the crisis service system, especially at local hospital emergency rooms
3. **Pathways Out:** Where individuals go after crisis intervention services are provided to continue the process of stabilization and recovery
4. **Resources and Supports:** The nature of the resources and services that are available across multiple systems to assist in crisis response and stabilization activities

Work Group Reports

Each of the four groups that met at the September 13th retreat created a detailed report of their discussion. These reports are included in Attachment #1 to this report. A brief summary of each group's report is provided below.

Pathways In Group

Key first responders who encounter persons in crisis in the community:

- Public Safety
- Primary healthcare
- Mental health and social services
- Natural support systems

How people in crisis become known to the systems of care:

- Self-referral
- Family and friends
- Police and public safety
- Existing service providers

What happens at first response to a specific crisis:

- Evaluation
- Ensuring safety of the individual and others
- Brief intervention
- Referral
- Engagement

Gaps and needs in the existing crisis response system:

- A "medical home" for the individual
- Engagement services
- Substance abuse treatment on demand
- Transportation
- Knowledge and expertise among first responders
- "Glitch free" collaboration between community mental health centers and emergency rooms
- Funding and resources for people in crisis

Possible solutions to the gaps and needs:

- Immediate access to walk-in crisis services (ER alternatives)
- Regional mobile crisis response teams
- Immediate access to detoxification services
- Improved transportation
- CIT training/first responder training in legal issues
- Public education to break "Emergency Room Addiction"
- Forensic inpatient units

- Increased funding and flexibility
- Increased collaboration and partnership

Emergency Room and Crisis Services Work Group

Defining the population for the current discussion:

- Acutely suicidal or homicidal (202A) will have their needs met; because of this, the primary target for the current discussion are persons in crisis, but voluntary patients (not 202A), often with co-occurring alcohol or substance involvement

How and when the target population ends up in the emergency room:

- Referred there by jailers, family, police, other hospitals, doctors, schools, etc.
- Few barriers exist to accessing ER services: "We never close"
- Mental health crisis most often appears at the ER after hours when family and friends can provide transport
- "Family fatigue" may delay response to emerging crisis; the crisis may be worse by the time the person gets to the emergency room

Suggested emergency room and crisis system improvements:

- Standardized protocols
- Integrated screening for substance abuse
- Expansion of detoxification bed capacity
- Education of consumers about crisis services
- Crisis line, e.g., routing 211 calls to a CMHC
- Family support services
- Peer support services
- Crisis stabilization services provide 23-hour holding beds
- Develop ER alternative "safe spaces"
- Transportation from the ER to services or home

Pathways Out Work Group

Options after the emergency room for continuing crisis stabilization:

- Another emergency room
- Home, family or friends
- Jail
- Shelter
- State hospital
- Private inpatient facility (medical or psychiatric)
- Crisis stabilization
- Drug treatment

- Other levels of care
- Transitional or permanent supportive housing
- Supports for Community Living program
- Streets

Possible linkages to MH/MR-funded services to assist in ongoing crisis stabilization:

- Prevention, education and self-help
- Outpatient services
- Case management
- Crisis Stabilization Unit
- Mobile crisis services
- Therapeutic rehabilitation
- Intensive outpatient services
- Residential treatment
- Emergency housing
- Rental vouchers
- Private inpatient care (not MH/MR funded)
- Family physician (not MH/MR funded)

Barriers to change in the existing crisis response system:

- 202A legal issues: Law is problematic
- Limited options within short timeframes
- Contract physicians
- Background checks for shelter services
- COBRA, EMTALA and HIPAA
- Lack of transportation
- Lack of housing
- Lack of training
- Counties without jails
- Lack of discharge planning from the emergency room
- Lack of outpatient services funding
- Manpower burdens on law enforcement
- Waiting lists, bed availability
- Fragmented systems

Possible alternatives to the current crisis response environment:

- Changes to 202A law
- Expanded CIT services
- Hospital/CMHC Memorandum of Agreement
- Use of peer supports, including NAMI, etc., in ER and transitioning services
- Improved CMHC response time

- Tele-health in the emergency room
- Transportation to after-hours services
- Hospital alternatives
- Coordinated discharge planning/gate keeping
- Use of a crisis and support line (possibly 211)
- On-call CMHC evaluation capacity in emergency rooms
- Crisis case management
- Training for emergency room staff
- Training for CMHC staff

Resources and Supports Work Group

Local and regional resource needs to enhance crisis response services:

- Systems navigators
- De-escalation and prevention services
- Better resources for law enforcement
- More training for first responders
- Clarification of CMHC role in emergency room response
- Increased capacity to address co-occurring disorder issues

Potential resources and sources of support for crisis response system enhancement:

- Private hospitals
- State hospitals
- Diversion dollars from Administrative Office of the Courts
- Department of Corrections
- Probation & Parole
- Local criminal justice funds
- Department of Community Based Services
- Community mental health centers
- Decriminalization funds
- Crisis stabilization resources
- Community medication support funds
- Medicaid
- Local mental health tax revenues

Strategies for maximizing resources for crisis response and stabilization:

- Keep solutions local
- Increase service coordination
- Provide training
- Reduce system barriers and silos
- Improve communication across systems and stakeholders

- Make current capacity availability known
- Develop transportation alternatives

General Commission Discussion

After the four groups had reported their findings to the reassembled HB 843 Commission, the group identified eight key focal points and five emerging "axioms" to guide future activities and action steps.

Key HB 843 Focal Points

- Reducing stigma associated with mental illness, substance use disorders and co-occurring disorders
- Educating about the issues across multiple systems
- Accessing transportation for people in crisis and recovering from crisis
- Addressing co-occurring disorders in an integrated fashion
- Providing continuity of care before, during and after a crisis
- Ensuring communication and collaboration across systems and services
- Promoting integration of all systems involved in crisis response and stabilization
- Identifying and aligning of existing resources

Emerging HB 843 Axioms to Guide Actions

1. We need more services/resources at the community level to prevent/divert/intervene before a crisis occurs
2. Best uses of existing funding must be maximized
3. There are some excellent practice models already in place that can be disseminated and replicated
4. Consumer and family perspectives are critical
5. Communication is at the root of many of our problems and is the source of some of the solutions

Next Steps

The Commission agreed that next steps to address the underlying issue/problem area would require two separate sets of activities at two different levels of the system (state and regional). These are:

A. Resource Identification (State Level)

Because the issues and problems involved in responding to the needs of persons experiencing behavioral health crises reach across multiple systems, no one agency or system, on its own, has the resources, expertise or skill set to solve the problem on its own. To be effective, a solution will need to reach across multiple systems, employing

the resources and expertise of all of the agencies and organizations that touch a person in crisis.

For this reason, it will be necessary to:

1. Describe precisely the resources in each system that are or could be made available to help address the needs of persons experiencing behavioral health crises; and,
2. Determine how best to organize and deploy these resources to maximize both the efficiency and effectiveness of crisis response services; and,
3. Identify additional resources that are needed to effectively address the problem and best meet the individual needs of persons in crisis.

B. Service Configuration

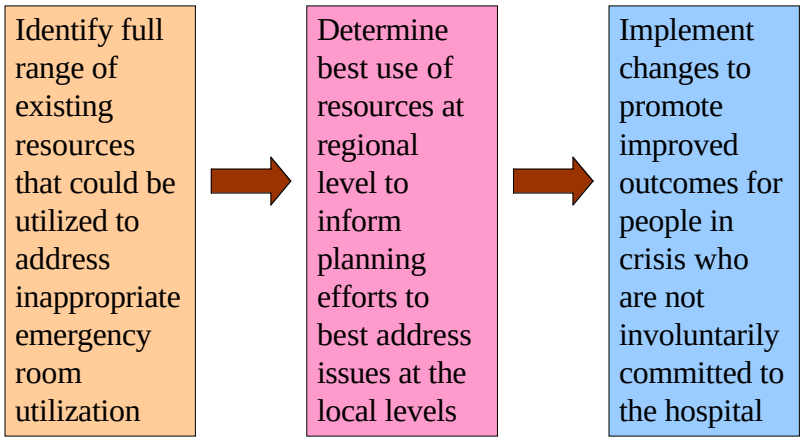
Because each of the 14 regional mental health systems in Kentucky faces a unique set of circumstances related to their geography, demography and existing service system structures, each regional will need to develop a configuration for crisis response services that is tailored to the needs of their communities and incorporates the specific features of their region. This activity will require identifying the current flow of individuals into, through and out of the crisis system, and the development of strategies and activities to improve this flow based on better deployment of available resources and services.

December 13th Retreat Work Products

The follow-up retreat of the HB 843 Commission convened on December 13th and was organized to address the two specific areas described at the first HB 843 retreat: *Resource identification and service configuration.*

A basic framework for a logic model for this work was described at the beginning of this work session, and is provided below:

Chart #2:
Framework for Logic Model: State and Regional Issues



Resource Identification

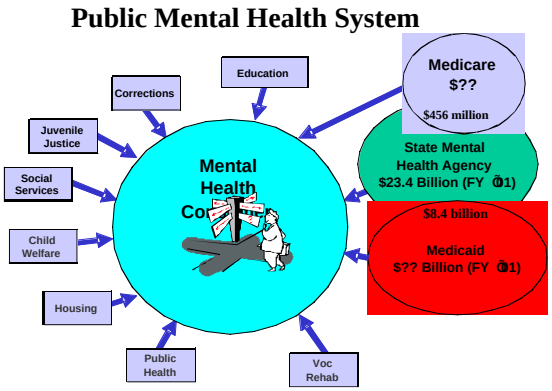
The first area tackled by the Commission at the December 13th retreat was resource identification. The Commission agreed that the task of identifying resources that could be made available to help address the needs of persons experiencing behavioral health crises who present at local hospital emergency rooms is an activity that must begin at the state level, but then needs to be translated into potential solutions at the regional and local levels. Resource identification requires that the relevant systems, (note: any system that has any contact with persons in crisis is a relevant system), must work together to "map" the funds across all systems that are or could be applied to addressing crisis response. This mapping process, if it is to lead to an alignment of resources across systems, must address the following questions and develop a consensus among the participating agencies:

- What are the opportunities presented by a comprehensive mapping of resources at the state level?
- What are the barriers that stand in the way of creating a comprehensive resource map?
- What can be done to eliminate these barriers?
- Which state entities, public and private agencies have resources to be identified?
- What is the full range of funding streams in Kentucky that should be included in a resource mapping discussion?

Lou Kurtz, the Associate Director for Planning at KDMHMRS, offered one model for approaching this resource mapping process. The model, called the "Other State Agency" Project (OSA), was developed and funded by SAMHSA in collaboration with

NASMHPD and provides a protocol for gathering and reporting data on mental health services across multiple systems. The protocol is illustrated in the following chart:

Chart #3: Other State Agency Project Resource Mapping Protocol



The OSA project, to be implemented in Kentucky in the first four months of 2007, offers opportunities to identify the following:

- The full range of mental health services and related expenditures being provided across state government, by fund source
- The opportunities to coordinate and reduce barriers to services
- The overlap between clients served by KDMHMRS and other agencies (e.g., how many clients are being served by both agencies)
- Strategies to develop a better picture of unmet needs for mental health services by providing a more complete picture of service provided and not provided by state agencies
- A methodology through which all agencies can actively participate in the development of comprehensive mental health system plans
- Opportunities to maximize resources and redirect resources to improve services

The Commission was excited about the OSA project, and identified that it has the potential to facilitate a number of opportunities, including to:

- Have real decision makers at the table (identify key decision makers)
- Focus on middle-managers in changing the culture (need to inform them and break down resistance)
- Look at funding streams (e.g. fund collaborative efforts instead of competitively)
- Obtain accurate data and then use it to make decisions
- Promote work toward cross systems agreement on purpose and performance measures.

- Start small – identifying "quick wins" (e.g. availability of notary's slows down the 202A process; recruit willing individuals to become notaries)
- Redefine mission and purpose (provide meaning and security for staff)
- Follow funding as far "upstream" as needed (silos start at federal level)
- Use existing resources effectively (there will be cost efficiencies if things are done "right" the first time)
- Consider change management strategies when thinking about culture change within organizations
- Use data
- Involve leadership
- Identify what the product is that consumers want and will use
- Find out what's not working well and determining not to fund it
- Use peer support specialists as strategy to deal with stigma
- Focus on a planning process first, in advance of the budget making process (and align both)
- Use resources to drive change.

During a general Commission discussion of a comprehensive mapping of system resources at the state level, Commission members stated that this mapping could or would:

- Provide a forum for communication between the people who are the proprietors of silos within the system. (To be effective, it must include the key decision-makers and those with authority to implement decisions.)
- Help to deal with the resistance from mid-level bureaucrats who may be resistant to change as a result of "protecting their turf".
- Promote approaches that fund programs and services collaboratively rather than competitively.
- Encourage participants to obtain and use data for funding decisions.
- Establish the value of change, and would help to convince the bureaucrats of the value of collaboration. (To do so, the process would need to identify goals, objectives, benchmarks and measures of outcomes.)
- Identify early, quick opportunities for victories by encouraging small, low-cost strategies for improvements.
- Help to re-define the meaning, purpose, mission and vision of the crisis response system as a way of reducing the threat to the bureaucrats.
- Assist in following funding streams "upstream" to find ways to reduce the restrictions on funding that create barriers.
- Promote the abandonment of a "scarcity mentality" and a "zero-sum-game mentality", and the adoption of thinking to maximize efficiency and effectiveness.
- Encourage leadership to support change through providing a sense of direction. (Leadership must provide persuasion and lead by example. Leadership must make a long-term commitment to changes.)

- Maximize consumer and family input and empowerment. (The outcomes of consumers and satisfaction with the system by consumers and family members must drive decision-making.)
- Drive a change process. (Careful planning should drive the processes of budgeting and funding, not vice-versa.)

In reviewing both the need for resource mapping and the opportunity provided by the Other State Agency study, the Commission agreed that clear and precise mapping the resources at the state level across all systems involved with crisis response services is a critical next in developing an effective response to the needs of individual residents of Kentucky who are experiencing a behavioral health crisis.

Service Configuration

The second area tackled by the Commission at the December 13th retreat was the configuration of services at the regional level. The group agreed that understanding the current service configuration at the regional level is critical to:

1. Identification of the gaps and barriers that exist to preventing individuals in crisis from receiving the services that they need to promote stabilization and recovery
2. Definition of alternatives to the status quo that involve rearranging or realigning existing services in order to better meet the needs of persons in crisis
3. Development of specific strategies targeting specific systems, services and interventions that offer the potential to change existing, dysfunctional service configurations to promote improved outcomes for persons in crisis
4. Measurement success over time at reconfiguring services to improve outcomes

Working with state and local stakeholders, and based on feedback received from the Commission at the September 13th meeting, the NASMPHD consultant developed a generic systems map of crisis services that could be used for development of an accurate depiction of crisis services within each region of the state. A copy of this systems map is include as Chart #4, on the following page.

The consultant recommended that this system map be used by each of Kentucky's 14 regions in a six stage process described below:

1. The regional mental health authority is ***provided with a copy of the systems mapping template*** (as contained in Chart #4)
2. The regional mental health authority is responsible for ***convening a work group*** to take the generic template and adjust the components of the map to ***create an accurate current depiction of the current flow of services*** for persons experiencing a behavioral health crises in their own community
3. The regional mental health authority, working with appropriate local stakeholders, ***creates a revised map depicting the desired configuration of services*** for persons experiencing behavioral health crises in their own community

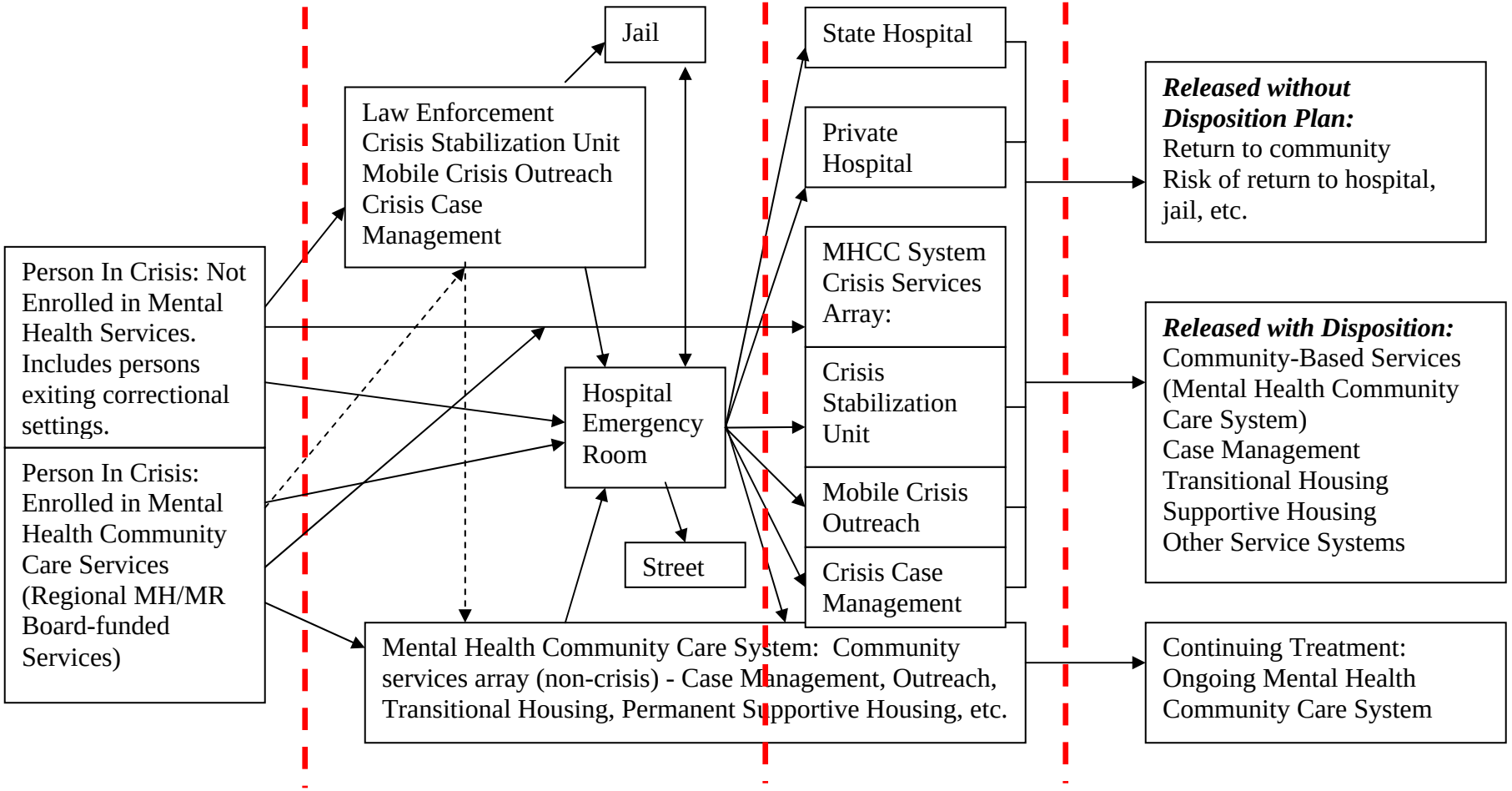
4. The regional mental health authority, working with stakeholders from the state, regional and local levels, ***identifies the existing and potential new resources that will be required to implement the changes*** contained on the revised map of services
5. The regional mental health authority, working with appropriate stakeholders, ***creates a strategic plan for moving their system towards the desired configuration*** of services
6. The regional mental health authority ***implements the strategic plan to change their system***, implementing the desired configuration of services for persons experiencing behavioral health crises

Although the HB 843 Commission liked the concept of regionally tailored systems mapping and strategic planning, the group identified a number of potential barriers and obstacles to this change process. Questions and issues discussed by the Commission included:

What are sources of resistance to change within the Community Mental Health Centers?

- The community and other systems have unrealistic expectations of the CMHCs, including a belief that the CMHCs have an inexhaustible source of funding and should therefore provide all needed services to all people for free
- There is a real shortage of funding for crisis response services

Chart #4: Psychiatric Crisis Response: Mapping System and Intercepts



Citizens in the Community

Pathways In: Immediate Response

Crisis Services: Stabilization

Pathways Out: Linkage to Ongoing Treatment, Housing and Supportive Services

- Requirements for "privileging" of staff within community organizations limits ability to meet community needs
- There is a perception within the community that CMHC services are of lesser quality that those of private providers
- There are too many legalistic concerns and concerns over liability and litigation
- The CMHCs are already saddled with many unfunded mandates, and the systems mapping and systems change process will become just another one of these competing priorities

How do we get participation in the Systems Mapping process at the regional level?

- Provide incentives for participation in the process; provide payment incentives to providers; provide financial incentives when systems collaborate and cooperate
- Demonstrate that the results of the process will help to drive funding decisions
- Utilize the existing HB 843 Regional Councils as the core structure for the process
- Seek appropriation of funds to support the process; alternatively, identify current funds that could be better utilized to support the systems mapping process
- Make increased flexibility in use of funding a carrot to attract participation; allow expansion of boundaries for use of funds
- Have the state mandate the process through contractual requirements

What other strategies could be utilized to stimulate implementation of increased funding and improved crisis services at the regional levels?

- Use old money in new ways: Find ways to change existing funding streams to support improvements to the crisis service system
- Maximize flexibility of funding allocations
- Create incentives to promote "braiding" of funding at the state and regional levels
- Use "carrots:" Provide funding based on performance; e.g. DIVERTS project
- Provide a "cash back bonus:" Create an incentive funding pool for meeting specified service levels
- Structure RFPs to require collaboration (pay for collaboration and outcomes)
- Use contracts to move CMHCs towards adopting recovery oriented models of care
- Fund outcomes (measurable change) rather than service volumes (simple units of service)
- Revisit crisis stabilization program funding utilization, including increasing the flexibility of funds earmarked for crisis response services
- Capitalize on existing relationships between organizations to explore alternatives for programmatic changes.
- Require regional mapping activities as a component of the contract DMHMRS signs with the CMHCs

- Educate the legislature regarding recovery-oriented services, with a focus on consumer/family input and involvement; establish education and re-education as an on-going process.
- Advocate for budget allocations to support the process.
- Use data and outcomes to identify strategies for re-allocation of existing funding.
- Utilize emerging evidence-based practices that stress peer support
- Educate consumers and providers about options
- Focus attention and resources on the issue of re-entry from prison/jail
- Revisit the hospital admissions policies with regard to the involvement of the CMHCs in screening
- Re-examine and clarify requirements of 202A and 504

Next Steps: Consultant Recommendations

The two meetings of the HB 843 Commission clarified that there is a great deal of interest in systems change and reform at both the state and local levels. The involvement of senior state-level officials will provide the momentum needed to sustain a change process. The involvement of service providers will help to inform realistic expectations about the pace and content of needed systems changes. The active involvement of consumers and family members will help to insure that the process remains focused on getting the right mix of needed services to the identified target populations: Residents of Kentucky who experience behavioral health crises.

The momentum created by the Commission's interest in crisis services, combined with the work of the Other State Agency study offers a rare opportunity to promote real change in a timely fashion. To that end, the consultant recommends the following next steps in order to help move forward the process initiated during these two retreats:

1. **Engage all relevant state agencies in the work of identifying the resources that are currently, or could potentially be utilized to enhance crisis services.** This means examining both the resources that are currently used for this purposes as well as resources currently being deployed in other program areas that might better be utilized to address crisis response services. For example:

    - The current configuration of funds supporting the Crisis Stabilization Units should be careful examined to determine, region-by-region, if these resources are being put the best possible use
    - Funds and staff time dedicated to the training of law enforcement professionals should be examined for possible reallocation to training about behavioral health issues (e.g., Crisis Intervention Team training)
    - Opportunities for the braiding of resources across systems should be explored and piloted, including the creation of formal relationships between the local hospital emergency rooms and community mental health centers for expedited access to services for persons in crisis presenting at local hospitals

2. **Require each regional authority to assume responsibility for mapping the configuration of crisis services in their area.** The six-step mapping process, described above, should include both a description of the current environment as well as a desired alternative system in which integrated crisis services are available. Steps to help facilitate this process could include:

    - Placing language in the state contracts with the regional mental health authorities that requires the completion of local systems maps of the crisis system
    - Requiring the regional mapping teams to describe alternative crisis service system configurations
    - Developing future contracts for crisis services that are aligned with the alternative systems described by each region, with the flexibility to accommodate what may be significant regional variations in service configurations

3. **Utilize existing and emerging evidence-based practice models to inform systems change in Kentucky.** There is already a range of models operating or under development within the state that provide opportunities for replication either regionally or statewide. These include:

    - Crisis Intervention Teams for law enforcement professionals
    - The DIVERTS program, serving a multi-county region with enhanced hospital and community linkages for individuals in crisis who need ongoing stabilization and recovery-oriented services
    - The discharge planning and reintegration program targeting individuals returning to the community from correctional settings
    - The development of formal Memoranda of Agreement between local hospitals and community mental health centers

4. **Keep the Kentucky HB 843 Commission actively involved in identifying and promoting solutions to crisis service system issues.** Because of its composition, stature and authority, the Commission offers an ideal venue for supporting the process of systems change at both the state and regional levels. The Commission and its staff could:

    - Provide regular briefings and progress reports to the Commission, and through the Commission to the Governor and Legislature, on both the resource mapping activities completed at the state level and system mapping activities completed at the regional level
    - Utilize the Commission to monitor progress and stimulate the change process at both the state and regional levels
    - Engage Commission members in active advocacy at the state level for the system and statutory changes needed to support the change process, as well as

for the resources required to ensure the adequacy of crisis services for every resident of Kentucky

Attachment #1

Summary of September 13, 2006 Work Group Reports

1. Report of the Pathways In Work Group

The task of the group was to answer a series of questions related to how individuals with mental illness who are in crisis enter into the crisis response system. Specifically, the questions to be addressed were:

- Who are first responders and what is their role?
- How do people in crisis come to the attention of first responders?
- What do first responders do, and where do they take people in crisis?
- What could be done differently to improve the ways in which people in crisis find the systems of care that can assist them and what first responders do?

The group was instructed that the answers to the first three questions were intended to focus on the current system, describing what is, rather than what should be. The group was also instructed that it was to take the broadest possible perspective, and not focus only on the mental health system. The group was further instructed that it needed to consider the diversity of the state, and the often dramatic differences between regions of Kentucky.

It was noted that first responders might be first responders in some situations but later responders in others. For instance, the Emergency Room may be the first responder for individuals who take themselves to the ER, while in many other cases the first responders are others who take the individual to the ER, thus making the ER a later responder. However, in most cases, their place in the chain of responders has little to do with the function carried out by the responder – the ER is likely to do much the same with an individual bringing themselves to the ER that they do with an individual brought to the ER by concerned family members.

The Work Group identified a *list of first responders*, which were later categorized into four main groupings, as follows (note that some responders are included in more than one of the groupings):

- **Public Safety**
  Police
  EMT and Paramedics
  Sheriffs
  Fire and Rescue Department Personnel
  911 Dispatchers

- **Primary Healthcare Providers**

Residential Service Providers, incl. Nursing Home, Personal Care, etc.
Emergency Rooms
Primary Care Clinics, including Specialty Healthcare Facilities
Hospital In-Patient Units (i.e., for people already in hospital)
Physicians

- **Mental Health and Social Service Providers**
  Community Mental Health Centers (CMHC)
  Emergency Rooms, including State Hospital
  Primary Care Clinics
  Psychiatrists and other Mental Health Professionals
  Specialized Residential Service Providers (Group Homes, etc.)
  Crisis Hotlines
  Consumer/Family Organizations
  Homeless Shelters and other Homeless Services Organizations
  Department of Community-Based Services Programs (DCBS)

- **Natural Support Systems**
  Family
  Clergy
  School Personnel
  Consumer/Family Organizations
  Friends and Acquaintances
  Employers/Supervisors

The second question to be addressed was to list the *mechanisms whereby individuals in crisis come to the attention of first responders*. This list included

- Self-referral – some individuals in crisis present themselves to first responders
- Contact from family or friends – this includes family or friends calling police, taking out MIWs, bringing individuals in crisis to emergency rooms, clinics, healthcare and mental healthcare settings or other service agencies, etc.
- Police and other public safety personnel – individuals in crisis may come to the direct attention of police or other public safety personnel as a result of disruptive behavior, or police may be alerted to individuals through other mechanisms, such as 911 calls, warrants, etc.
- Awareness by existing service providers – providers who already have an on-going relationship with people may become aware of the development of crises, and therefore become first responders as part of their on-going work with the individual in crisis. This includes Community Mental Health Center staff, staff at DCBS, or staff in a variety of community agencies and organizations, including physicians, psychiatrists and other mental health professionals in the private sector.

The third question that was addressed was to develop a *description of what first responders do and where they take people.* The Work Group identified the following list of activities carried out by first responders:

- Evaluate the individual. The first activity for most first responders includes an evaluation – sometimes this is a formal evaluation of the individual to determine if they meet the criteria under KRS 202A for involuntary hospitalization, while in other cases the evaluation is more focused on identifying the nature of the crisis and necessary interventions.
- Find a safe place for the individual to go. Significantly, it was noted that most first responders seek to find a place or a situation where individuals in crisis can go that will fulfill the need to protect their safety and the safety of the community. For community responders (police, CMHC staff, family, etc.), the ER is often the place most commonly identified where an individual can be taken that will assure that they are safe. When the ER itself is the responder, a hospital, state hospital or crisis stabilization unit is often the safe place for the person to go. In a few cases, a detox facility is the safe place for a person to go, although detox facilities are in short supply in Kentucky.
- Brief intervention and release. For people who do not need to go to a secure location for protection of themselves or the community, many first responders will intervene with the individual in crisis and then release them to their natural environment. CMHC staff, physicians and psychiatrists, ERs and others may well take this limited action, depending on the circumstances. Often this action is coupled with…
- Referral to a provider. For those responders who do not have an on-going relationship with the individual in crisis (such as CMHCs, physicians, etc.), the first responder may provide a brief intervention and then make a referral to some provider or other resource for short- or long-term follow-up. For instance, this is the typical action taken by crisis hotlines, and by ERs that determine that in-patient hospitalization is not called for. If the first responder already has an on-going relationship with the individual in crisis, then they may carry out activities intended to…
- Engage the individual in needed programs and services. This would be the typical response of CMHC staff, which might respond to the individual in crisis by bolstering the services to the individual, becoming more assertive in outreach and engagement activities, etc.

It should be understood that this list is in no way exhaustive, but only reflects the primary strategies that the Work Group was able to identify in the limited time available.

The final question addressed by the Work Group focused on *suggested possible alternatives to improve the ability of first responders to effectively deal with individuals in crisis.* To discuss the issue of improvement, the Work Group necessarily identified problems or weaknesses in the current system. These problems included:

- Lack of a "Medical Home" for some individuals. It was noted that a number of those individuals who present in crisis at ERs are people who do not have an on-going relationship with a physician, psychiatrist, CMHC or other service provider who is available to intervene as needed. Thus, the ER becomes the first responder for people who are not in crisis, but who have no alternative response system, or for people whose problems have risen to a crisis level because they have no on-going support and treatment system to intervene before problems reach the crisis stage. This includes many of the uninsured, who cannot afford regular care from community providers, but also may include Medicaid recipients and others who are not engaged in any community service system.
- Lack of engagement in services or adherence to treatment. Clearly related to the first bullet point, the Work Group expressed a concern that many people who may have a "medical home" still may not be effectively engaged in services, or may be non-adherent to the treatment being offered. In some cases, this lack of engagement and adherence is the result of service systems failing to offer services that are attractive or desirable to the individual, or not otherwise being responsive to the individuals' own perceived needs.
- Lack of immediate availability of substance abuse services. The overall lack of detox services, and the long waits for other substance abuse services, were identified as contributing to the failure of the community service system to provide services that would help to avoid the development of crises.
- Lack of transportation resources. Kentucky is a very rural state, with the percentage of residents living in rural settings being three times the national average. The social isolation that is created by this circumstance is exacerbated by the lack of affordable public transportation systems. The lack of transportation resources thus not only contributes to difficulty in accessing needed services, but also makes community engagement in normal activities difficult, leading to social isolation that undermines effective community functioning and avoidance of crises.
- Lack of knowledge and expertise of first responders. The Work Group expressed a concern that many first responders may not have the appropriate knowledge base and expertise to respond effectively to people with mental illnesses who are in crisis. This includes public safety personnel and other first responders who are not in the mental health system, but also may include some individuals who work within the mental health system itself.
- Stigma. Some individuals may avoid availing themselves of existing services and supports in the community because of fear of the stigmatizing effect of becoming engaged in the mental health system. Thus, because individuals working within the existing community service system are not in contact with individuals, they are not in a position to be first responders, and the ER becomes the first line of response because crises have not been averted through regular contact and support.
- Glitches in collaboration between CMHCs and ERs. The Work Group expressed the opinion that there exists a lack of mutual understanding about the respective roles of the ERs and CMHCs, which produces glitches in attempts to work collaboratively. ERs and CMHCs both may have a wide array of misconceptions

about each other's roles and responsibilities that make for sometimes ineffective working relationships between the organizations.

- Inadequate funding/resources. While the Work Group recognized that more money is not always the answer, and that existing resources can often be utilized more effectively, it was still an inescapable conclusion that many improvements in the response system for people in crisis will require additional funding and resources.

The group then identified some possible alternatives that could improve the effectiveness of first responders in meeting the needs of persons in crisis. These alternatives included:

- Immediate availability of walk-in crisis intervention capacity as an alternative to the ER. One option that could be instituted to reduce the dependency on the ER would be the development of an alternative crisis intervention program with a physical location that could serve as an alternative to people going to or being taken to the ER. Such services might be co-located with Crisis Stabilization Units, or could be freestanding services. Detox capability in this location would be a plus as well. The availability of this type of facility could significantly reduce the inappropriate utilization of the ER, which often defines its role with people in psychiatric crises as being primarily a decision-making one to determine if the individual should be admitted to an inpatient unit or not; when the decision is "not", the individual is often simply released back to the community with no intervention or direct follow-up.
- Regional Mobile Crisis Response Teams. Another alternative, which could be instituted in conjunction with a crisis intervention walk-in facility or as a freestanding program, would be the establishment of Regional Mobile Crisis Response Teams, which could travel throughout the region to respond to individuals in crisis. Providing immediate intervention in the natural environment could substantially reduce inappropriate utilization of ERs.
- Immediate access to detox services. Regardless of whether a walk-in crisis program can be instituted, changes in the system to make detox services available on an immediate basis would serve to enable many people who currently go to the ER to instead receive detox services; after sobering up, many people no longer need to be seen in an ER setting.
- Improve transportation resources. The lack of transportation resources is a problem that creates problems in many areas; the discussion by the Work Group regarding transportation was wide-ranging, and included both issues relating to first responders as well as to the more specific issue of transportation of individuals for hospitalization. The on-topic discussion focused on the inability of individuals to have access to transportation to participate in a variety of community activities or to obtain community resources, which could help them to avoid crises; social isolation has been implicated as a factor in such issues as suicide and other social ills. Thus, the lack of transportation resources is a major contributor to the development of crises, as well as presenting barriers to accessing needed services to avoid problems and crises. The off-topic discussion focused on the lack of a shared understanding of the role of the public mental

health system and the law enforcement system in being responsible for transporting individuals for hospitalization; while this was not part of this Work Group's focus, it was nevertheless identified as an important issue to clarify and address.

- Promote CIT training. Since lack of knowledge and expertise of first responders was identified as a shortcoming of the system, it was suggested that CIT training – which is specifically aimed at improving knowledge and expertise among law enforcement personnel concerning effective intervention techniques with people with mental illnesses – be a focus of development across the state.
- Consistent training in civil commitment law for all first responders. As with the previous item, the lack of clear understanding of civil commitment law produces problems for first responders. The recommendation of the Work Group is that a consistent training module be developed for use in delivering training to all first responder groups in civil commitment law, regulation and practice.
- Public education to break the ER addiction. Any changes in the system to provide alternatives to the use of ERs as the first line of response for crises should be accompanied by public education efforts to bring about a change in thinking by the public about what they should do during a crisis; this would promote the use of alternatives to the ER.
- Promote collaboration and partnerships. It is obvious that an effective crisis response system is dependent upon a wide array of community organizations and resources. Collaboration at the local level and the development of local partnerships between healthcare, mental health, law enforcement, etc. would serve to promote the development of local crisis response systems that address processes that may be unique to the locality.
- Develop forensic in-patient unit(s). While somewhat off-topic for this particular Work Group, there was a recommendation that the state develop forensic in-patient unit or units to address unmet need for people who were formerly served in the Grauman Unit at Central State Hospital. This would help to address the problem of the "revolving door" for some individuals who frequently come into contact with the crisis response system.
- More funding. As noted before, while changing the utilization of existing funding resources can bring about some of the proposed improvements, it is unrealistic to believe that the system can be dramatically improved without the influx of additional funds. And in a related recommendation;
- Increased funding flexibility. The ability of the crisis response system to respond quickly and effectively is hampered by funding restrictions that limit who can do what, and where and when they can do it. Removing restrictions on how public funding can be utilized would help each locality throughout the state to develop the most appropriate crisis response systems to meet their unique needs and circumstances.

Several of the problem areas identified were not addressed in the listing of possible alternatives to the service system. This was not due to a lack of concern or interest on the part of the Work Group, but simply to the short amount of time available to the group for discussion. Additional discussion of alternatives, based on some of the specific problem

areas identified, should be carried out to expand the range of possible strategies to address the problems.

2. Report of the Pathways Out Work Group

Describe options for people exiting the emergency room

- Other emergency room
- Home / family / friends
- Jail
- Shelter (general homeless or domestic violence)
- State hospital
- Private inpatient (medical or psychiatric)
- Crisis stabilization unit
- The Streets
- Drug treatment programs (detox, 28 day program, etc.)
- Other levels of care
- Transitional or supportive permanent housing
- SCL program

What ongoing services and supports are available to them?

Regional MH/MR Board (various levels of care including):

- Prevention/ education / self-help
- Outpatient
- Case management ("regular" or crisis case mgmt.)
- CSU
- Mobile crisis
- Therapeutic rehabilitation program with case management
- Intensive outpatient
- Residential treatment for substance abuse
- Emergency housing
- Rental vouchers
- Private inpatient

Providers other than Regional MH/MR Board:

- Outpatient
- Family physician

What types of relationships exist between the hospital and these entities?

"It's horrendous!!"

No really, it depends on the ER and the region they are in. Kentucky River Community Care (KRCC) has an MOU with ARH Psychiatric Center but not with the ER. Most ERs have no formal relationships with the providers of services that might be options for a quick discharge from an ER.

What barriers exist that prevent people from accessing these services now?

- The involuntary process - 202A ("It's a horrible law!", "It's a travesty!")
- Timeframes (options really are not available given the short period of time needed to discharge someone)
- Contract physicians
- Background checks in shelters
- No reimbursement if not admitted
- COBRA / EMTALA / HIPAA (huge barriers to moving someone from ER to other location)
- Transportation
- Lack of training for all involved
- Counties without jails
- Lack of discharge planning in the emergency room
- Funding (majority of funding in the public system is still on the inpatient side)
- Rules for getting into shelters
- Manpower (burden on law enforcement)
- Lack of forensic hospital inpatient beds (creates huge barriers to options listed earlier)
- Waiting lists; bed availability in various programs
- Liability insurance for law enforcement
- Lack of CIT officers
- Training, training, and more training!! (For all first responders)
- At least four statutory barriers identified by Representative Siler
- Lack of housing
- Lack of system integration
- Lack of usable education and training for consumers and family members

What could be done differently?

- Change 202A legislation (e.g. dual signatures required by judge and notary, two hearings, sheriff transportation issue, sovereign immunity, etc.)
- Use peer support specialists in the ER and in transition out of ER
- Quick response from CMHC
- Tele-health in ER
- NAMI / family members on-site at all state hospitals
- Transportation after hours (e.g. the Pathways model)
- Discharge planning (need supply of medications, need one entity involved in discharge process, "No Wrong Door", Single point of entry, etc.)

- Use the developing 211 system as an alternative to 911 or establish another 1-800 number
- On-call evaluation in ERs by CMHC (some have it, others don't – it's primarily a funding issue)
- Crisis case management (could be jointly funded by ER, CMHC or other entities)
- Competency of ER doctors and nurses in treating mental health and substance abuse issues could be a focus of training (e.g. assessing risk, QPR, could serve as QMHP for 202A process)
- Model agreements between CMHCs and ERs (like the jail triage agreements)
- Model curriculum for ER staff
- Expand CIT programs
- Create more alternatives to inpatient psychiatric hospitalization (e.g. in-home crisis services, personal care home beds, 23 hour beds, etc.)
- Create more transitional and permanent supportive housing options
- ER staff need to be knowledgeable and protected (i.e. the liability issues)
- Case managers located in ERs (they could serve a linkage function as well as triage)
- Must have someone or an agency serving in a "gate keeping" function

3. Report of the Emergency Rooms and Crisis Services Work Group

<u>Defining the Population in Question</u>

- Initial discussion was focused upon defining the population in question; essentially, describing the individual who are arrives at the ER in psychiatric crisis.
- Acutely suicidal or homicidal person who is in crisis (the involuntary – 202a client)
- Person in crisis who is a voluntary client – the individual believes he or she are in crisis but the System (202a admission) does not recognize him or her as in crisis
- Alcohol or other substances are involved
- The hospital can "admit & transfer" or "admit & treat"
- The 202a client will have his or her needs met; therefore, the primary concern is the voluntary client

<u>How do voluntary clients get to the ER?</u>

- List of potential referral or transportation sources developed by the group:
    1. Jailers
    2. Home
    3. Police
    4. Family
    5. Other Hospitals
    6. Private Doctors
    7. Schools
- One member of the group reported that the ER's in which she works average 8 to 12 hours wait time for individuals presenting with a mental health crisis.

Barriers to Accessing ER Services

- It was noted that accessing ER services is relatively easy for most individuals. Therefore, there are not many barriers.
- It was noted that many individuals presenting with a mental health crisis might do so after hours because that is when family and friends are available to transport to the ER due to their respective work schedules. Therefore, the delay in accessing ER services may be considered a barrier to timely services.
- Family fatigue may be another barrier. The family has become exhausted with dealing with the growing crisis and this fatigue delays their response to the individual.

Suggested Improvements to the System

- Develop of a standard protocol to be followed for individuals with a mental health crisis presenting at an ER.
- The protocol should include screening for substance abuse
- There should not be separate protocols or systems for mental health and substance abuse. Both MH and SA should be addressed by the same protocol and system.
- The protocol should include common language.
- Expansion of Detox beds.
- Consumers should be educated about crisis services.
- Develop of a crisis line similar to a 911 system. Currently, Louisville is implementing a 211 public service number. The 211 number could be used for mental health and substance abuse crises. A public awareness campaign could be started to publicize a common number.
- The 211 number could be routed to a Community Mental Health Center (CMHC) to answer the call and defer the individual to appropriate services. Call data could be tracked to determine the disposition of 211 calls.
- Family Support and Peer Support services can be utilized to prevent a crisis.
- Crisis stabilization services could be used as a 23-hour holding bed.
- A Safe Place could be used instead of the Hospital ER; such as a conference room in the community, a hospital room or the CMHC could contract for space in the community.
- Planning for a more appropriate ER response should include transportation away from the ER. Some individuals get to the ER and do not have away to a more appropriate services site or home.

4. Report of the Resources and Supports Work Group

Initial discussion centered on needs and local/regional responses to those needs.

The state psychiatric hospital reported an increase in admissions and readmissions and the private med-surgical hospitals reported no abatement of psychiatric crisis cases coming to the ER.

Question: is it that we are woefully lacking in community-based programs…and/or that we are not fully utilizing the capacity and resources that already exist? It seems to be both! One of the things that needs to be introduced/strengthened is a "navigator" function to help the consumer and other stakeholders move around the system from entry to needed services so that available resources are known and fully utilized.

Consumer and family member input emphasized the great need for more preventive programs – opportunities to de-escalate a situation before it becomes a crisis, which then has to be handled with more intensive, expensive and intrusive responses. All agreed.

One of the issues for law enforcement is the time and expense involved in transporting a person to the ER or to the CMHC and then waiting for the evaluation to be completed. It also can seriously deplete the availability of law enforcement personnel in the community. Increased resources for law enforcement in responding to persons in psychiatric crisis – whether in MIW situation or with voluntary psychiatric admissions are needed.

Another issue for law enforcement is the growing complexity of cases and the lack of commensurate training and education of personnel as to what to look for, how to respond most appropriately, etc. The Crisis Intervention Team (CIT) program was lauded for its intense educational component, but it has only been done in a handful of communities across Kentucky.

There was discussion around the role of the CMHCs in responding to calls from hospitals with ER admissions that are voluntary. There are numerous examples of the response from a CMHC to a specific hospital being done in a timely, efficient manner – most often, when there is a structured relationship between the two entities. There is no funding source for the CMHC to provide these evaluations for voluntary admissions.

There were examples given around the table of problems in credentialing/privileging CMHC personnel at a given hospital in order to have an evaluation done. Another problem is with individuals who come to the ER in crisis and are unable to be evaluated because of their current stage of addiction. The waiting time for the individual to become sufficiently sober or detoxed in order to be evaluated is costly to the hospital, to law enforcement, to the consumer, to the family, and to the potential evaluator, which is usually the CMHC.

There are many examples of local/regional initiatives to respond to the identified needs and problems. Around the table, these included:

Example: Claudia Smith (family member) and Jim Dailey (NAMI-KY) recently pulling together a community meeting in Nelson County to collaborate, communicate problem-solve – meeting with representatives from Flaget Hospital, County Judge, Chief of Police, community volunteers, NAMI and the CIT personnel to address the ER problem.

Example: Herb Bowling – CJ Training – described the very successful education of law enforcement around decriminalization issues in 1989 and later with the Jail Triage program; suggesting that the mental health issues portion of the law enforcement curriculum be strengthened, using that same voluntary educational approach.

Example: Cumberland River CMHC meeting with law enforcement in their region and finding additional funds to pay law enforcement personnel to transport individuals in psychiatric crisis to CMHC offices for the appropriate evaluation and referral to services that are needed.

Example: Consumers like Janet Massey are being trained to provide peer support services which have great potential to be plugged in at each of the intersects in the system. The most obvious problem in developing this cost-effective and useful resource is the current lack of reimbursement for these services.

Examiner: Dr. Haas from Department of Corrections reported on a program in which individuals with SPMI who are about to be released from the corrections program are hooked up to mental health resources within Seven Counties Services (SCS) through the work of two case managers hired by DOC. Individuals have access to 14 days of medication when released. One difficulty encountered was a period of time during which SCS had to limit intake to individuals being released from hospital treatment because of a shortage of funding to provide services to individuals without a payer source, including released inmates.

Example: DIVERTS program reported by Allison Ogden in which the four CMCH regions in the Western State Hospital (WSH) District are initiating region-specific programs to decrease state psychiatric hospital admissions and readmissions. The programs incorporate flexibility and regional variations such as establishing a gatekeeper model with a single point of entry. Responding to the advocacy of NAMI-KY to put more funds into community-based mental health programs, the Cabinet is funding the first stage of the DIVERTS program with $2M which had been targeted to open an additional inpatient unit at WSH. The plan is to roll out and fund the DIVERTS program in the remaining ten regions of the state in Phase 2.

Discussion then moved to identification of Current Funding Streams and the lack of shared information across systems about funding sources and programs.

<u>We need to be able to identify funding and resources from all available sources:</u>

Private Hospitals
State Hospitals
Diversion $$ / AOC
Dept. of Corrections/Probation & Parole
Local Resources (law enforcement, judiciary, etc.)
CMHC Funding (Block grant & General fund dollars)
Dept. of Community-Based Services (DCBS)
Decrim $$
Crisis Stab $$
Community Med Support $$
Medicaid
Local MH Taxes

In addition to the discussion of resources in dollars, the participants focused on other
aspects of resources which could be maximized:

- Keep solutions local
- Increase service coordination
- Reduce system barriers / silos
- Improve communication across the system / across all stakeholders
- Make current capacity availability known
- Transportation training/ alternatives

What can we learn from the Recovery KY model? Unlikely partners came together to address the some aspects of the substance abuse problem in the state.

How can we restructure the transportation problem to eliminate transportation?

--Greater use of tele-health and telemedicine